

**Authorization For Release of Psychotherapy Notes**

**Counseling & Relationship Institute**

**237 Lookout Place**

**Maitland, FL 32751**

**P: (407) 865-3855 F: (321) 203-2512**

Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_

This is to authorize \_\_\_\_\_ to discuss and release any  
information, including psychiatric and/or psychological records, of the above named  
individual to: \_\_\_\_\_

\_\_\_\_\_ (address),

\_\_\_\_\_ (phone),

Signed: \_\_\_\_\_  
(client \_\_\_\_, Client \_\_\_\_, Guardian \_\_\_\_)

Date: \_\_\_\_\_